DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G194	A. BUILDING _____ B. WING _____	06/15/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INNOVATIVE	114 DIVISION AVENUE, NE WASHINGTON, DC 20019

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W 000	INITIAL COMMENTS A recertification survey was conducted from June 12, 2007 thru June 15, 2007. The survey was initiated using the fundamental survey process. A random sample of three clients was selected from a resident population of four women and two men with various disabilities. The findings of the survey were based on observations, interviews with clients and staff in the home and one day program, as well as a review of client and administrative records, including incident reports.	W 000	RECEIVED JUN 29 2007 By	
W 120	483.410(d)(3) SERVICES PROVIDED WITH OUTSIDE SOURCES The facility must assure that outside services meet the needs of each client. This STANDARD is not met as evidenced by: Based on interviews and record review, the facility failed to ensure that the day program met the needs of one of three clients in the sample. (Client #1) The finding includes: Cross-refer to W159.1. On June 13, 2007, Client #1 was observed using a scoop plate and utensils with built-up handles while eating in his residence. He did not, however, have adaptive eating equipment available at his day program. Interviews with staff and the client in the day program and at home, followed by a review of Client #1's record revealed no evidence of a coordinated team approach to address the client's adaptive eating equipment needs and preferences.	W 120	W120 ILS will ensure on going communication with the day program as it relates to the adaptive equipment needs of consumers. QMRP will continue to provide day program monitoring. ILS will ensure PCP added adaptive equipment.	7/15/07
W 159	483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL	W 159		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Executive Director | (X6) DATE: 6/29/07

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 159	Continued From page 1 Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility's Qualified Mental Retardation Professional (QMRP) failed to adequately monitor, integrate and coordinate clients' active treatment programs and services, for three of the three clients in the sample. (Clients #1, #2 and #3). The findings include: 1. The QMRP failed to monitor and coordinate Client #1's adaptive eating equipment needs and preferences, as follows: a. On June 13, 2007, Client #1 was observed eating his breakfast when this surveyor entered the facility at 6:27 AM. He ate using a scoop plate and a spoon with a built-up, spongy handle. His name was written on the spoon handle in large letters. Later that day, at approximately 11:57 AM, the surveyor arrived for day program observations. The client and staff were interviewed in the cafeteria, beginning at approximately 12:03 PM. The client reported having just finished his lunch a few minutes earlier. Client #1 said that although he used a "regular" plate at the day program, he would prefer to use a scoop plate. He explained that he used the high side of theplate to keep food on his spoon. The styrofoam plates used at day program did not provide similar structure and he routinely used his fingers to push food onto his	W 159	W159 -a Feeding adaptive equipment for client #1 was provided to his day program on 6/25/07 (see attached). QMRP will continue to provide day monitoring on a monthly basis.	06/25/07

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W 159	Continued From page 2 spoon. The day program case manager and direct support/classroom staff person witnessed the interview. Moments later, they indicated that this was the first time that Client #1 (who demonstrated effective communication skills throughout the survey) had talked about using a scoop plate and/or specialized spoon. Client #1's day program chart was reviewed, beginning at approximately 1:05 PM. His May 2007 physician's orders did not reflect any adaptive eating equipment. An Individual Plan For Support Services (IPSS), prepared by the day program on October 3, 2006, included the following: "...uses regular utensils for mealtime." A day program Mealtime Protocol, dated 12/1/06, did not reflect use of any adaptive eating equipment. There was no evidence that the day program was aware of the client's use of a high sided scoop plate. b. During the same interview at day program on June 13, 2007, Client #1 said that while he was able to use the small white plastic spoons he was given for lunch, he preferred the spoon with a built-up, spongy handle used at home. He explained that it was easier for him to grip the adaptive handle. There was no evidence that the day program was aware of the client's preference for a specialized spoon. c. On June 13,2007, at 2:41 PM, the QMRP and LPN Coorindator were asked whether Client #1's use of a scoop plate and built-up handled spoon were clinically indicated or based on the client's preferences. They both stated they thought the occupational therapist (OT) had recommended both. The QMRP presented an OT progress note dated November 2006 that included the following:	W 159	W159-a ILS will have physician order that reflect the recommended adaptive equipment for client #1. W159-b OT will assess client adaptive equipment needs as well as consider client preference. W159-c ILS OT will clarify adaptive equipment recommendations. ILS clinical team will further modifications of mealtime protocol and forwarded to the day program as indicated.	7/15/07 7/15/07 7/30/07

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W 159	Continued From page 3 "Consumer to use and benefit from the following adaptive equipment: high sided plate... improve overall independence..." The OT note did not, however, mention an adaptive/specialized spoon. The client's Mealtime Protocol, signed by the nutritionist on 3/27/07, also reflected a "high sided plate." The QMRP stated that she had brought a copy of the updated residential Mealtime Protocol with her to the day program approximately 2 1/2 weeks prior to the survey. The QMRP, however, acknowledged that she had not observed him eat lunch at the day program. d. Client #1's health and habilitation records were reviewed in the home, beginning on June 13, 2007, at 2:54 PM. Notable inconsistencies were found among the various professional assessments and recommendations, physician's orders and the annual plan (ISP) as follows: - while the OT had written a "progress note" in November 2006 recommending use of a "high sided plate" (fax dated December 2006), an "annual OT assessment," dated 4/18/07, no longer referred to a high sided plate. The OT assessment had "N/A" in the section that addressed eating Guidelines and Adaptive Eating Devices. It should be noted that the sign-in sheet failed to reflect participation by the OT in the 10/11/06 ISP meeting and the QMRP was unable to explain why the OT assessments and reviews were on a different time/track from those of other disciplines; - Client #1's most recent speech/language assessment, dated 11/27/05, indicated he "...eats and drinks independently after set-up by staff usig regular utensils and a hi-lo plate to facilitate scooping of foods..." - A quarterly nutrition review, dated 1/30/07, and a 3/27/07 nutrition "Re-Admit note" made no	W 159	W159-d The OT wrote an addendum to client #1 OT annual assessment on On 06/22/07 to reflect the feeding adaptive equipment for client # 1 (See attached). QMRP will review all assessment when submitted to ensure consistency in all clients Information. A monthly QA system has been instituted to ensure that consistency in information provided in all assessment are maintained.	7/30/07

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W 159	Continued From page 4 mention of adaptive eating equipment; - residential Mealtime Protocol, dated 3/27/07, reflected "high sided plate" but made no mention of a built-up handled spoon; - day program Mealtime Protocol, dated 12/1/06, did not reflect use of any adaptive eating equipment; - the client's POs did not include orders for any adaptive eating equipment; [Note: On June 14, 2006, at approximately 11:00 AM, the QMRP stated that the primary care physician (PCP) was aware of the scoop plate. During an onsite interview with the PCP in the facility on June 14, 2007, at 2:32 PM, he acknowledged that he did not include orders for adaptive equipment on his monthly POs. He further indicated that he signs or initials and dates other consultants' documents on which they make recommendations. However, review of the November 2006 OT progress note failed to show evidence that the PCP had reviewed the document; - Health Manegement Care Plan (HMCP), dated 10/2006 and updated 3/27/07 did not reflect use of a high sided plate or built-up handled spoon; - LPN Coordinator monthly reviews only listed the motorized wheelchair as adaptive equipment, until the May 2007 Monthly, dated 6/6/07, that also listed "build-up spoons and forks" (no mention of scoop plate); - Client #1's Individual Support Plan, dated 10/11/06 included "also use scoop plate and a regular spoon for feeding..." and, - the QMRP 2nd quarter review, dated 4/4/07, did not reflect his use of a scoop plate or built-up handled spoon. There was no evidence of a coordinated interdisciplinary team review and consensus regarding Client #1's adaptive eating equipment needs and/or preferences. In addition, the client's	W 159	W159-e ILS will ensure PO reflects adaptive equipment. The HMCP will also reflect appropriate change to adaptive equipment needs. QMRP will ensure consistency of documentation of adaptive equipment needs.	7/15/07

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W 159	Continued From page 5 known preference to use an adaptive spoon with built-up handle had not been assessed by the OT and was not reflected in his annual plan and mealtime protocol. 2. The QMRP failed to ensure consistency and accuracy of Client #1's Axis I diagnoses, as follows: - During the June 13, 2007 morning medication pass, Client #1 was observed receiving Prozac 60 mg and Haldol 2 mg. - Psychiatric Assessment, dated 5/18/06, included the (one) following Axis I diagnosis: "296.34 Major Depressive Disorder, chronic, with psychotic features;" - Psychotropic Medication Reviews, dated 9/20/06, 10/18/06, 11/15/06, 12/20/06, 1/24/07, 2/21/07, 4/18/07, and 5/16/07, listed schizophrenia (only); - Psychological Evaluation, dated 10/9/06, listed both depression and schizophrenia; - June 2007 physician's orders listed depression (only); - RN Nursing quarterlies, dated 7/31/06, 12/31/06 and 4/7/07, listed schizophrenia (only); and yet his - nurse-prepared HMCP, dated 10/2006 and updated 3/27/07, reflected a diagnosis of depression. 3. Cross-refer to W249. The QMRP failed to ensure that Client #2's self-medication training program was implemented as written. 4. Cross-refer to W194. The QMRP failed to ensure that staff were effectively trained on when to use Client #3's prescribed gait belt during ambulation. 5. Cross-refer to W436.3. The QMRP failed to	W 159	W159 - 2 Updated psychiatrist assessment will be obtain to reflect current axil I diagnosis for client #1. An addendum will be done to all assessments to reflect this changes .QMRP will ensure that all assessments are reviewed when submitted to ensure consistency in clients diagnosis. QA system has been instituted to ensure accuracy in all clients' assessment. W159 - 3 ILS nursing coordinator will conduct training for medication nurses on the implementation of self-medication program. The LPN coordinator and QMRP will randomly monitor the medication nurses to ensure the implementation of program.	7/30/07 7/15/07

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W 159	Continued From page 6 ensure that staff consistently made available Client #3's prescribed gait belt during ambulation.	W 159		
W 194	483.430(e)(4) STAFF TRAINING PROGRAM Staff must be able to demonstrate the skills and techniques necessary to implement the individual program plans for each client for whom they are responsible. This STANDARD is not met as evidenced by: Based on observations, interviews and the review of records, the facility staff failed to demonstrate competency in implementation of Client #3's ambulation program. The finding includes: On June 13, 2007, at 7:08 AM, Client #3 was observed receiving 2-person assistance to stand up from the breakfast table. She then used metal crutches to walk from the dining room over to a bathroom located next to her bedroom. For the first 10 feet, a direct support staff person walked behind the client, holding a gait belt. Beyond the first 10 feet, the Qualified Mental Retardation Professional (QMRP) took over, assisting the client towards the bathroom. The QMRP walked to the client's left side while holding the gait belt. Later that day, at 4:42 PM, Client #3 walked into the living room, using her crutches. This time, however, the client was not wearing the gait belt. A direct support staff person was walking behind her. The staff person held the client's lower shirt and upper waist band in the back with one hand. At 4:46 PM, the QMRP was asked about Client #3's gait belt. The QMRP stated that the physical therapist (PT) had recently added the gait belt as	W 194	W194 PT will provide ongoing training To staff to ensure consistency and continuity of care in the ambulation with client #3. PT will document needed uses of Gait belt for ambulation and provide parameters for uses.	6/26/07

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W 194	Continued From page 7 a safety measure, "in case she slips." The QMRP described the client's exercise program. The gait belt reportedly was optional; staff could use it if they did not feel comfortable supporting the client without one. The gait belt could be used during the exercise program and for navigating through the facility, dependent on the staff person's comfort level. On June 13, 2007, at 6:24 PM, Client #3 asked for staff assistance to leave the dining room table. Two persons assisted her to stand up and then one direct support staff person walked to the client's right side, holding the client by her armpit, as the client used her crutches to walk 4 feet to a nearby chair. The client was without the gait belt. On June 15, 2007, at 4:25 PM, the QMRP confirmed that she had stated the gait belt was optional; the decision on whether the client should wear it was dependant upon the staff person's comfort level. Review of Client #3's PT records revealed that the client should wear the gait belt for fall prevention. On May 31, 2007, the PT documented having trained staff on the use of the gait belt. In addition, "it was discussed and decided to use contact guard assistance... during ambulation and transfers.... providing assistance at her trunk and pelvis... the gait belt is a secondary measure." The PT recommended use of the gait belt "as a safety measure to assist with fall prevention" and "use contact guard assistance during mobility." Review of the staff in-service training records revealed that of the 12 direct support staff on the weekly schedule, only 3 of them (1/4) were in attendance for the 5/31/07 PT training. Of the 2 direct support staff persons observed assisting	W 194	W194-b Staff will receive training on the use of the Gait belt and assistance to be given during transfers.	6/26/07

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W 194	Continued From page 8 the client without use of the gait belt, 1 had attended the training while the other had not (6:24 PM and 4:42 PM, respectively). It should be noted that the QMRP acknowledged that she had not attended the 5/31/07 training.	W 194	W194 The Physical Therapy will in service staff on client #3 use of gait belt (see attached).QMRP will continue to ensure that client #3 IPP goals and objective are implemented as written.	6/26/07
W 249	483.440(d)(1) PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to implement programs as outlined in the Individual Program Plan (IPP) for one of the three clients in the sample. (Client #2) The finding includes: During the medication pass observation on June 13, 2007, the nurse prepared medications in a nursing area located in the basement and administered them on the first floor. At 8:10 AM, the nurse punched Client #2's medications into a cup and carried them upstairs. At 8:17 AM, she gave the cup with medications to Client #2. The nurse did not give the client an opportunity to punch medications from the bubble pack. At 9:01 AM, review of the the client's Individual Program Plan (IPP) objectives revealed that the client had a self-medication objective to punch two of her	W 249	W249 ILS nursing coordinator will conduct training for medication nurses on the implementation of self-medication program. The LPN coordinator and QMRP will randomly monitor the medication nurses to ensure the implementation of program.	7/15/07

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W 249	Continued From page 9 medications from their bubble packs. Review of the data collection sheet revealed that for June 13, 2007, the designated space in which the nurse should document this aspect of the self-med program had been left blank.	W 249		
W 331	483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure nursing services in accordance with the needs of one of the three clients in the sample. (Client #2) The findings include: 1. Nursing staff failed to ensure that Client #2's finger sticks were performed while fasting, in accordance with physician's orders, as evidenced by the following: a. During the survey, observations revealed that finger sticks were not performed while fasting. On June 13, 2007, Client #2 was observed finishing her breakfast at approximately 6:49 AM. The medication nurse arrived in the facility at 7:29 AM. At 7:38 AM, the nurse administered a finger stick and Client #2's glucose reading was 163. During the verification process, at 9:03 AM, review of the client's June 2007 Medication Administration Record (MAR) revealed the following: "fasting/sugars twice a day (8 AM and 5 PM)" with 7 AM written by hand as the designated morning time. When asked about finger sticks later that morning, at 9:24 AM, the	W 331	W331-a RN and PCP will determine adequate and appropriate parameters for the monitory of client #2 finger stick.	7/30/07

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W 331	Continued From page 10 LPN Coordinator stated that "it has to be fasting." At 9:31 AM, the LPN Coordinator was on the telephone with the primary care physician, who confirmed that the finger sticks should be "before the meal." The client's June 2007 physician's orders (POs) had "Fasting/Sugars twice a day (8 AM-5 PM)." That evening, the client's finger stick also was not performed while fasting. The client finished eating a cup of yogurt at 4:42 PM. At 5:04 PM, 22 minutes later, the nurse was observed asking Client #2 to come with her in order to perform a finger stick. b. Client #2's medical records indicated an ongoing pattern of non-fasting finger stick readings that went undetected by the nursing staff until brought to their attention during the survey. On June 13, 2007, at 9:24 AM, when asked about the timing of finger sticks, the LPN Coordinator stated that "it has to be fasting" and she thought they routinely were being done while fasting. When informed of the 131 reading taken 49 minutes after the client ate her breakfast, the LPN Coordinator indicated that she did not believe that was a typical morning pattern. The consultant medication nurses maintained a monthly "Blood Sugar Log" chart on which they recorded Client #2's morning and evening finger stick readings. On June 15, 2007, at beginning at 2:30 PM, review of the January 2007 chart revealed: - entries dated 1/3/07 and 1/15/07 in which the morning nurse wrote "147 (after breakfast)" and "197 (after breakfast)," respectively. - there were numerous mornings that the nurse documented readings that were comparable to the one taken on the morning of June 13, 2007 (131 mg/dl) which was achieved 49 minutes after her breakfast.	W 331	W331-b LPN will be in-service on obtaining finger stick blood sugars and the specific protocols that should be followed..	7/15/07

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W 331	Continued From page 11 For example: 1/4/07 131 mg/dl; 1/6/07 152; 1/7/07 237; 1/8/07 134; 1/10/07 127; 1/17/07 129; 1/18/07 119; 1/19/07 131 and so on. - By contrast, the January 2007 chart showed six mornings with readings in the 82 - 98 range. For example: 1/5/07 82 mg/dl; 1/9/07 92; 1/12/07 90 and 1/13/07 98). - Evening glucose readings fluctuated between as low as 97 (on 1/28/07 and 1/30/07) upwards to a high of 171 (on 1/8/07). Review of Client #2's February, March, April, May and June 2007 blood sugar logs revealed similar findings. There were numerous morning and evening readings in the 130's, 140's and higher throughout the six-month period. It should be noted that Client #2's diabetes was largely controlled by diet and the use of Glucotrol, 5 mg by mouth twice daily. However, the client's April 2007 Blood Sugar Log indicated that on 4/21/07, an AM reading of 295. The nurse documented having administered 4 units insulin that morning. Review of the client's POs, however, revealed that she should receive 2 units of insulin for readings 251-300 (and 4 units if reading is 301-350). This represents a medication error for that morning. That was the only time documented that she received an insulin injection. It should be further noted that Client #2's POs indicated that nursing staff were to notify the primary care physician if readings went below 60 or above 400 mg/dl. Although there was no written evidence that the client's blood glucose levels went outside those parameters during the period 1/1/07 - 6/14/07, the absence of reliable fasting blood glucose readings could not confirm	W 331	Staff will be reminded not to allow client to eat before AM blood sugar has been checked and LPN will be reminded of need to arrive at facility earlier in the morning. PM staff will be reminded to hold evening meal until LPN has the opportunity to check her evening blood glucose levels	7/30/07

ITEMENT OF DEFICIENCIES D PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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W 331	Continued From page 12 that levels never dropped below 60 mg/dl. Readings taken on the mornings of 1/5/07 (82 mg/dl), 1/9/07 (92), 1/12/07 (90), 1/13/07 (98) and other mornings would suggest that her fasting levels did fall within that range. 2. Facility nurses failed to ensure accuracy of Client #2's Health Management Care Plan (HMCP). On June 14, 2007, at 4:08 PM, review of Client #2's HMCP, signed/dated September 20, 2006 and March 27, 2007, revealed the following: "Finger sticks should be done before each meal and before bedtime." However, interviews with nurses and review of her June 2007 POs following the medication pass observation of June 13, 2007 had indicated that her finger sticks were to be administered twice daily. When interviewed again on June 14, 2007, at approximately 4:12 PM, the LPN Coordinator stated that what was outlined in the HMCP had "never been the order... the order has always been <finger sticks> twice daily." 3. On June 13, 2007, review of Client #2's self-medication assessment, dated August 1, 2006, failed to show evidence that facility nurses had assessed the client's strengths/skills and needs regarding blood glucose finger stick testing. Observations, interviews and record review revealed that nurses were performing finger sticks twice daily to monitor blood glucose levels. On June 15, 2007, at 3:01 PM, interview with the LPN Coordinator confirmed that the client had not been assessed to determine whether or not she could perform the finger sticks herself, or acquire the skills necessary to achieve greater independence in this routine, daily health maintenance task. As noted above, the client was observed eating her breakfast meal (with her	W 331	W331-2 RN will ensure that HMCP accuracy reflects the Health care needs of client #2. PCP will provide clarification of order for Client #2. HMCP will be modified to reflect current finger stick blood sugar orders W331-3 RN assessed client #2 on 10/11/06. ILS will ensure that assessment is available and part of the Clients Client #2 will be assessed to determine appropriateness of performing her own finger stick blood sugar testing. If it is determined that client has the ability to perform self-checks, she will be trained to perform her finger sticks before meals.	7/30/07 7/30/07

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W 331	Continued From page 13 peers) before the nurse entered the facility that morning. Also noted above, there was other documentation indicating that the client routinely ate her breakfast with her peers before the nurse arrived to administer the finger stick. 4. Cross-refer to W394. Nursing staff failed to obtain a Certificate of Waiver as required under the Clinical Laboratory Improvement Amendments of 1988 Act (CLIA) before administering finger stick testing of Client #2's blood sugar levels, twice daily. 5. Cross-refer to W249. Nursing staff failed to implement Client #2's self-medication training program as written. 6. Facility nurses failed to ensure accuracy of Client #1's Health Management Care Plan (HMCP). On June 13, 2007, at 3:42 PM, review of Client #1's HMCP, dated October 2006 and March 27, 2007, revealed no evidence that the client used any adaptive eating equipment. Observations, interviews and record review revealed that Client #1 routinely used a high-sided scoop plate and utensils with built-up handles while eating in the facility. It should be noted that Client #1's health and habilitation records revealed no evidence that the client's interdisciplinary team had fully assessed and reviewed his adaptive eating equipment needs and preferences. [See W159.1] 7. On June 14, 2007, at approximately 11:42 AM, review of Client #1's health and habilitation records failed to show evidence of a current Annual Nursing Assessment. There were 2nd and 3rd quarter nursing reviews, dated 4/20/06	W 331	W331-4 Certificate of waiver Application for administering finger stick testing has been completed and forward to appropriate state agency for processing W331-5 Training on self-medication program for client # 2 will be done. QMRP and LPN will provide random monitory of implementation. W331-6 See W159 W331-7 Annual nursing assessment was completed on 10/11/06 assessment will be provided in medical record	6/27/07 06/17/07 10/11/07

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W 331	Continued From page 14 and 7/31/06 respectively. His interdisciplinary team (IDT) met on 10/11/06 to update his annual plan; however, there was no corresponding nursing assessment in the record. A 1st quarter nursing assessment, dated 4/7/07, was in the record. At 12:19 PM, the QMRP agreed to seek whatever nursing assessment might have been made available to the IDT for their 10/11/06 ISP meeting. No additional information was made available prior to the conclusion of the survey at 6:00 PM on June 15, 2007. 8. Nursing staff failed to address Client #1's expressed complaints about the flavor of his medications. Client #1 was observed refusing his medications on June 13, 2007, between 6:00 PM - 7:00 PM (at which time this surveyor departed the facility for the night). At approximately 8:00 AM the next morning, interview with the client revealed that he had taken his medications last evening "except for the powdered one." He said he didn't like the taste. At 10:43 AM, the LPN Coordinator informed this surveyor that he had taken his medications at 7:15 PM the previous evening. Interview with the LPN Coordinator revealed that the client previously (date/s not specified) had complained about the flavor of the Glycolax powder that was prescribed to prevent constipation. He received 4 packets every evening, dissolved in 4 glasses, totaling 32 fluid oz. The client reportedly had told the nurse he would drink it if they put sugar in it. Further interview, however, revealed that the nursing staff had not approached the primary care physician or the gastro-intestinal specialist for recommendations on how they might flavor the medication to make it more palatable to the client.	W 331	W331-8 Nursing staff will explore and document Client #1 complain of medication.. RN will consult with pharmacist to determine if there is anything that can be added to Glycolax to improve the flavor. ILS will also discuss alternatives in medication with PCP and Gastroenterologist.	7/15/07
W 394	483.460(n)(2) LABORATORY SERVICES	W 394		

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W 394	Continued From page 15 If the laboratory chooses to refer specimens for testing to another laboratory, the referral laboratory must be certified in the appropriate specialties and subspecialties of service in accordance with the requirements of part 493 of this chapter. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to obtain a Certificate of Waiver as required under the Clinical Laboratory Improvement Amendments of 1988 Act (CLIA) before administering finger stick tests for blood sugar glucose levels, for the one of six clients residing in the facility receiving routine finger sticks. (Client #2) The finding includes: On June 13, 2007, at 7:38 AM, the medication nurse administered a finger stick to Client #2 and took a reading of her blood glucose (163 mg/dl). She indicated that finger sticks were performed twice daily. This was confirmed at 9:03 AM through review of the client's June 2007 Medication Administration Record and Physician's Orders. At 5:04 PM, the evening nurse was observed asking Client #2 to come with her for her finger stick. On June 15, 2007, at approximately 2:25 PM, the facility's LPN Coordinator was asked whether the facility had obtained a Certificate of Waiver, as required under the Clinical Laboratory Improvement Amendments of 1988 Act (CLIA). She telephoned the agency Director. At approximately 2:35 PM, the Director indicated that he was unaware of the requirement. He was	W 394	W394 See W331 #4 W394 See W331 #4	

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W 394	Continued From page 16 directed to W394 and then provided "internet address" to the location on the federal CMS website pertaining to CLIA. At 5:18 PM, the Registered Nurse consultant responsible for overseeing nursing services telephoned the facility. She informed the surveyor that the Food and Drug Administration had waived the need for a certificate. It was her understanding that the facility was not required to obtain anything in writing. She too was directed to W394 and provided "internet address" to the location on the federal CMS website pertaining to CLIA.	W 394		
W 436	483.470(g)(2) SPACE AND EQUIPMENT The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure that clients were provided with and taught to use their adaptive equipment, such as scoop plates and gait belts, for two of the three clients in the sample. (Clients #1 and #3) The findings include: 1. Cross-refer to W159.1. On June 13, 2007, Client #1 was observed using a scoop plate and utensils with built-up handles while eating in his residence. He did not, however, have adaptive eating equipment available at his day program. Interviews with staff and the client in the day	W 436	W436-1 See W159	

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W 436	Continued From page 17 program and at home, followed by a review of Client #1's record revealed no evidence of a coordinated team approach to address the client's adaptive eating equipment needs and preferences. 2. Cross-refer to W194. Client #3 was observed using metal crutches to walk in her residence. Staff provided physical assistance, to varying degrees, to stand up and while walking. The client had recently been prescribed a gait belt for use as a safety measure while ambulating. Facility staff did not, however, consistently implement the use of the gait belt, as evidenced by the following: On June 13, 2007, at approximately 7:10 AM, a direct support staff person and the Qualified Mental Retardation Professional (QMRP) walked behind the client, holding a gait belt. Later that day, at 4:42 PM, Client #3 walked into the living room. This time, however, the client was not wearing the gait belt. A direct support staff person was walking behind her. The staff person held the client's lower shirt and upper waist band in the back with one hand. Later that day, at approximately 6:26 PM, a direct support staff person walked along the client's right side, holding her by the armpit. The client was without the gait belt. Interviews with the QMRP on June 13, 2007 and on June 15, 2007 revealed that she (the QMRP) thought use of the gait belt was optional; staff could use it if they did not feel comfortable supporting the client without one. The gait belt could be used during the exercise program and for navigating through the facility, dependent on the staff person's comfort level.	W 436	W436 - 2 See W194 W436-2 See W194	

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W 436	Continued From page 18 However, review of Client #3's PT records revealed that the client should wear the gait belt for fall prevention. On May 31, 2007, the PT documented having trained staff on the use of the gait belt. In addition, "it was discussed and decided to use contact guard assistance... during ambulation and transfers... providing assistance at her trunk and pelvis... the gait belt is a secondary measure." The PT recommended use of the gait belt "as a safety measure to assist with fall prevention" and "use contact guard assistance during mobility." Facility staff did not, however, consistently implement the use of the gait belt to ensure the client's safety. It should be noted that of the 12 direct support staff listed on the weekly schedule, only 3 of them (1/4) had attended an in-service training provided by the PT on 5/31/07. The QMRP also acknowledged that she had not attended the 5/31/07 training.	W 436	W436-2 See W194	

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I 000	INITIAL COMMENTS A licensure survey was conducted from June 12, 2007 through June 15, 2007. A random sample of three residents was selected from a resident population of four women and two men with various degrees of disabilities. The findings of this survey were based on observations at the group home and one day program, interviews with residential and day program staff and residents, as well as the review of clinical and administrative records, including incident reports.	I 000		
I 082	3503.10 BEDROOMS AND BATHROOMS Each bathroom that is used by residents shall be equipped with toilet tissue, a paper towel and cup dispenser, soap for hand washing, a mirror and adequate lighting. This Statute is not met as evidenced by: On June 15, 2007, at 5:44 PM, the following observations were made in the bathrooms located on the main floor: a. There were no paper cups and no paper cup dispenser in the bathroom located nearest Resident #2's bedroom b. There were no paper cups in the cup holder in the bathroom nearest to the living room.	I 082	1082 a The cup holder in the bathroom located nearest #2 bathroom has been refill with paper cups and there is cup dispenser is now . Staff will ensure that the cup holder has paper cups at all time and also Staff will make sure that there is a cup dispenser in the bathroom at all time. 1082 b The cup holder in the bathroom nearest to the living room has been refill with paper cups. Staff will ensure that the cup holder has paper cups at all time.	6/27/07 6/27/07
I 206	3509.6 PERSONNEL POLICIES Each employee, prior to employment and annually thereafter, shall provide a physician ' s certification that a health inventory has been performed and that the employee ' s health status	I 206	1206 ILS will put a QA system in place to ensure that direct care staff, nurses, Physiologist and behavior specialist file are updated accordingly	7/30/07

Health Regulation Administration

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Health Regulation Administration

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I 000	INITIAL COMMENTS A licensure survey was conducted from June 12, 2007 through June 15, 2007. A random sample of three residents was selected from a resident population of four women and two men with various degrees of disabilities. The findings of this survey were based on observations at the group home and one day program, interviews with residential and day program staff and residents, as well as the review of clinical and administrative records, including incident reports.	I 000		
I 082	3503.10 BEDROOMS AND BATHROOMS Each bathroom that is used by residents shall be equipped with toilet tissue, a paper towel and cup dispenser, soap for hand washing, a mirror and adequate lighting. This Statute is not met as evidenced by: On June 15, 2007, at 5:44 PM, the following observations were made in the bathrooms located on the main floor: a. There were no paper cups and no paper cup dispenser in the bathroom located nearest Resident #2's bedroom b. There were no paper cups in the cup holder in the bathroom nearest to the living room.	I 082	1082 The cup holder in the bathroom located nearest to resident #2 bathroom has been refill with paper cups. QMRP and Facility Manager will check bathroom daily to ensure that the cup holder has paper cups at all time.	06/26/07
I 206	3509.6 PERSONNEL POLICIES Each employee, prior to employment and annually thereafter, shall provide a physician ' s certification that a health inventory has been performed and that the employee ' s health status	I 206	1206 ILS will put a QA system in place to ensure that direct care staff, nurses, Physiologist and behavior specialist file are updated accordingly	7/30/07

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I 227	Continued From page 2 for 5 of the 12 direct support staff ([redacted], [redacted], [redacted], [redacted] and [redacted]) working in the facility.	I 227	1227 The current first aid for [redacted], [redacted], [redacted] and [redacted] are attached	
I 230	3510.5(g) STAFF TRAINING Each training program shall include, but not be limited to, the following: (g) Habilitation planning and implementation; This Statute is not met as evidenced by: See Federal Deficiency Report - Citation W194	I 230		
I 274	3513.1(e) ADMINISTRATIVE RECORDS Each GHMRP shall maintain for each authorized agency ' s inspection, at any time, the following administrative records: (e) Signed agreements or contracts for professional services; This Statute is not met as evidenced by: Review of the GHMRP's personnel files on June 15, 2007, beginning at 4:50 PM, revealed that the three medication nurse consultants had signed partial written agreements with the GHMRP. These agreements were general in nature and did not outline the nurses' duties. The written agreements for all other health care professionals included a second part, Attachment A, that outlined in detail the "services to be provided by the consultant." There was no Attachment A that described the duties of a medication nurse. On June 20, 2007, at 1:00 PM, a written agreement for one of the medications nurses was received via facsimile. Review of the Attachment A, however, revealed that it was applicable to	I 274		

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I 274	Continued From page 3 someone in a supervisory position. A 1:35 PM telephone conversation with the QMRP revealed that the Attachment A was for the LPN Coordinator position, not a med nurse. There was no evidence that an Attachment A had been established for the three medicationnurse consultants employed by the facility.	I 274	1274 ILS will ensure that a written detail attachment of service to be provided by contractures medication as part of their contractures general agreement.	
I 379	3519.10 EMERGENCIES In addition to the reporting requirement in 3519.5, each GHMRP shall notify the Department of Health, Health Facilities Division of any other unusual incident or event which substantially interferes with a resident ' s health, welfare, living arrangement, well being or in any other way places the resident at risk. Such notification shall be made by telephone immediately and shall be followed up by written notification within twenty-four (24) hours or the next work day. This Statute is not met as evidenced by: Review of incident reports revealed 3 significant incidents that were not reported to the Department of Health, as follows: 1. An incident report dated 3/17/07 indicated that Resident #1 was taken to an emergency room (ER) after complaining that his stomach hurt and he vomited. Note: A 3/18/07 return to the ER for identical symptoms was reported in accordance with regulations. 2. An incident report dated 10/16/06 indicated that staff discovered a burn mark on Resident #2's arm. The resident reported having burned herself while using an iron a few days earlier.	I 379		7/30/07

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I 379	Continued From page 4 3. An incident report dated 9/16/06 indicated that Resident #4 was returning home from a scheduled surgical procedure when staff observed urine leaking from a catheter onto the surgical wound area. Staff were instructed to return him to the hospital. The catheter was replaced and he returned home the same day.	I 379	1379 The Agency's incident Management policy and procedure will be revised The agency will ensure that all incidents are reported to the IMC and DOH within 24hours and all investigations and completed with 5 working day. QA system will be institute whereby all incidents will be review monthly at the management meeting.	06/26/07
I 403	3520.5 PROFESSION SERVICES: GENERAL PROVISIONS Each professional service provider shall participate on each resident ' s interdisciplinary team as appropriate to the resident ' s Individual Habilitation Plan. This Statute is not met as evidenced by: There was no evidence that the GHMRP ensured the participation of the Occupational Therapist in the interdisciplinary team process, in planning and reviewing Resident #1's adaptive eating equipment needs and preferences. See Federal Deficiency Report - Citation W159.1.c/d	I 403	1403 In the future QMRP will ensure that OT participates in inter disciplinary team process in planning and reviewing of residents.	06/26/07
I 407	3520.9 PROFESSION SERVICES: GENERAL PROVISIONS Each GHMRP shall obtain from each professional service provider a written report at least quarterly for services provided during the preceding quarter. This Statute is not met as evidenced by: On June 14, 2007, at approximately 11:42 AM, review of Resident #1's health and habilitation records failed to show evidence of a current Annual Nursing Assessment. There were 2nd	I 407		

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G194	A. BUILDING _____ B. WING _____	06/15/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INNOVATIVE	114 DIVISION AVENUE, NE WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
I 407	Continued From page 5 and 3rd quarter nursing reviews, dated 4/20/06 and 7/31/06 respectively. His interdisciplinary team (IDT) met on 10/11/06 to update his annual plan; however, there was no corresponding nursing assessment in the record. A 1st quarter nursing assessment, dated 4/7/07, was in the record. At 12:19 PM, the QMRP agreed to seek whatever nursing assessment might have been made available to the IDT for their 10/11/06 ISP meeting. No additional information was made available prior to the conclusion of the survey at 6:00 PM on June 15, 2007.	I 407	1407 See W331-7	
I 420	3521.1 HABILITATION AND TRAINING Each GHMRP shall provide habilitation and training to its residents to enable them to acquire and maintain those life skills needed to cope more effectively with the demands of their environments and to achieve their optimum levels of physical, mental and social functioning. This Statute is not met as evidenced by: On June 13, 2007, review of Resident #2's self-medication assessment, dated August 1, 2006, failed to show evidence that facility nurses had assessed the resident's strengths/skills and needs regarding blood glucose finger stick testing. Observations, interviews and record review revealed that nurses were performing finger sticks twice daily to monitor blood glucose levels. On June 15, 2007, at 3:01 PM, interview with the LPN Coordinator confirmed that the resident had not been assessed to determine whether or not she could perform the finger sticks herself, or acquire the skills necessary to achieve greater independence in this routine, daily health maintenance task. It should be noted that the resident was observed	I 420		

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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I 420	Continued From page 6 eating her breakfast meal (with her peers) before the nurse entered the facility that morning. In addition, there was other documentation indicating that the resident routinely ate her breakfast before the nurse arrived to administer the finger stick.	I 420	W1420 Refer to W331-3	
I 422	3521.3 HABILITATION AND TRAINING Each GHMRP shall provide habilitation, training and assistance to residents in accordance with the resident ' s Individual Habilitation Plan. This Statute is not met as evidenced by: Based on observation, interview and record review, the GHMRP failed to provide treatment and services in accordance with two of the three sampled residents' Individual Habilitation Plans. (Residents #2 and #6) The findings include: See Federal Deficiency Report - Citations W159, W249, W331 and W436	I 422	W1422 Refer to W159, W249, W331 and W436.	